

USFHP Prior Authorization Request Form for semaglutide oral tablet (Ozempic)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? Call 1-877-880-7007

<https://www.usfamilyhealth.org/for-providers/pharmacy-information/>

Prior authorization does not expire. Clinical documentation may be required.

Step 1 Please complete patient and physician information (please print):

Patient Name:	_____	Physician Name:	_____
Address:	_____	Address:	_____
Sponsor ID #:	_____	Phone #:	_____
Date of Birth:	_____	Secure Fax #:	_____

Step 2 Please complete the clinical assessment:

1. Is the patient 18 years of age or older?	☐ Yes Proceed to question 2	☐ No Stop Coverage not approved
2. Does the patient have a documented diagnosis of type 2 diabetes mellitus ¹ ?	☐ Yes Proceed to question 3	☐ No Stop Coverage not approved
3. Has the patient tried and had an inadequate response to metformin, or has a contraindication to metformin?	☐ Yes Proceed to question 4	☐ No Stop Coverage not approved
4. Is the patient able to adhere to the administration requirements (take on an empty stomach with no more than 4 oz. of water at least 30 min before the first meal of the day)?	☐ Yes Proceed to question 5	☐ No Stop Coverage not approved
5. Is the patient a female AND pregnant?	☐ Yes Stop Coverage not approved	☐ No Proceed to question 6
6. Does the patient have a history of pancreatitis?	☐ Yes Stop Coverage not approved	☐ No Proceed to question 7
7. Does the patient have a personal or family history of medullary thyroid carcinoma (MTC)?	☐ Yes Stop Coverage not approved	☐ No Proceed to question 8

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8. Does the patient have multiple endocrine neoplasia syndrome type 2 (MEN2)?	☐ Yes Stop Coverage not approved	☐ No Sign and date below
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¹ Non-FDA approved uses are not approved including weight loss (obesity) or type 1 diabetes mellitus

Step
3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature

Date

[05 May 2026]